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Office of Administrative Law Judges
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Issue Date: 06 January 2005

In the Matter of:
JOHNIE H. ISOM
Claimant

Case No.: 2003 BLA 5251

v.

EASTERN ASSOCIATED COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. S. F. Raymond Smith, Attorney
For the Claimant

Mr. Paul E. Frampton, Attorney
For the Employer/Insurer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

This matter involves a claim filed by Mr. Johnie H. Isom for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural History[1]

On April 26, 2001, Mr. Isom filed a claim for black lung disability benefits under the Act (DX 1).[2] Following pulmonary examinations and consideration of conflicting chest x-ray interpretations, the District Director denied the claim on August 8, 2002 for failure to prove the presence of pneumoconiosis (DX 19). Mr. Isom appealed the adverse decision on August 28, 2002 and the case was forwarded to the Office of Administrative Law Judges on December 2, 2002 (DX 37) for a hearing. Although Administrative Law Judge Robert J. Lesnick set a hearing date of August 6, 2003, he approved the employer's continuance request, without an objection from claimant's counsel, on July 17, 2003. Pursuant to a Notice of Hearing, dated August 20, 2003, I conducted a hearing in Beckley, West Virginia on December 10, 2003. Mr. Isom, Mr. Smith and Mr. Frampton attended the hearing.

Unfortunately, after the hearing, on January 12, 2004, Mr. Isom passed away. In light of the Claimant's death, Employer's counsel requested that I remand the case to the District Director. Claimant's counsel objected and on behalf of the surviving spouse requested that I adjudicate the claim after leaving the record open for a period of time for receipt of post-mortem evidence. On May 5, 2004, I denied the Employer's remand request. Rather than remanding the claim to the District Director, I kept the record open through August 9, 2004 for the submission of both additional evidence and closing briefs.

Evidentiary Discussion

At the hearing, despite the absence of an objection from Claimant's counsel, I deferred a decision on the admissibility of Dr. Fino's medical opinion, marked EX 3 and EX 7 (post-hearing deposition), because the employer had already offered the medical evaluation/opinion by Dr. Zaldivar, DX 31, and the medical opinion of Dr. Branscomb, EX 1 (TR, pages 11 and 15). Under the evidentiary restrictions in 20 C.F.R. § 725.414 (a) (3) (i), an employer is limited to two medical reports as part of its affirmative case-in-chief.

Employer's counsel, Mr. Frampton, offered two reasons for the admission of Dr. Fino's medical report. First, Dr. Fino's report is admissible as rebuttal evidence to the U.S. Department of Labor ("DOL") pulmonary examination conducted by Dr. Rasmussen and in evidence as DX 13. Second, due to the complex nature of Mr. Isom's pulmonary condition, good cause exists to admit an additional, relevant medical opinion under the regulations. Notably, unlike the other opinions by Dr. Zaldivar and Dr. Branscomb, Dr. Fino's assessment focuses on the etiology of Mr. Isom's pulmonary fibrosis.

In terms of rebuttal, 20 C.F.R. § 725.414 (a) (3) (ii) limits an employer's response to "one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study,

[1]Mr. Isom believed that he filed a previous claim for black lung disability benefits in the early 1980s and the claim had been denied. The record before me does not contain a previous black lung claim (*See* Transcript, pages 21and 23).

[2]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

autopsy or biopsy submitted by the claimant. . ." In that regard, I first note that as rebuttal to Dr. Patel's interpretation of the DOL chest x-ray, the Employer already offered Dr. Scatarige's interpretation of the film as DX 30. Additionally, Dr. Fino merely summarized the DOL pulmonary test results and did not actually re-interpret the pulmonary function test or arterial blood gas study. Accordingly, Dr. Fino's review of, and conclusions about, all the medical evidence in the record is not admissible as rebuttal evidence to the DOL pulmonary evaluation.

Concerning good cause, in developing its case-in-chief, the Employer was free to chose Dr. Fino's medical report instead of the evaluations of either Dr. Zaldivar or Dr. Branscomb. While I prefer to have all available medical evidence before me in adjudicating a black lung decision, the regulations restrict my access to such evidence except for showing of good cause. However, I find little reason to remove the evidentiary restrictions for good cause. Nearly every black lung claim of a miner who also smoked cigarettes presents a complex etiology issue about any pulmonary impairment. Considering the Employer had ample opportunity to select the most relevant medical opinion from its perspective on etiology, I do not find the existence of good cause in this case to permit the additional medical opinion by Dr. Fino. As a result, EX 3 and EX 7 are not admitted. Dr. Fino's medical report (EX 3) and subsequent deposition (EX 7) are marked, "offered, not admitted" and will be attached to the record.

During the adjudication of this claim, I discovered that Dr. Zaldivar included in his medical report his interpretation of the November 14, 2001 chest x-ray. The Employer had already submitted into evidence the interpretations of that chest x-ray by Dr. Wheeler and Dr. Scott. Consequently, Dr. Zaldivar's additional interpretation exceeds the evidentiary restriction contained in 20 C.F.R. § 725.414 (a) (3) (i) and is not admissible.[3]

Since his chest x-ray interpretation is inadmissible, I must also determine whether the remaining portion of his opinion may remain in evidence in light of the 20 C.F.R. § 725.414 (3) (i) additional mandate that a medical report may reference only medical information that is otherwise admissible under the regulations. Although his interpretation of the November 14, 2001 chest x-ray is inadmissible, Dr. Zaldivar also reviewed the two admissible interpretations of Dr. Wheeler and Dr. Scott, who reached the same conclusion as Dr. Zaldivar in regards to the film. As a result, I have decided not to exclude Dr. Zaldivar's medical report due to his chest x-ray interpretation. In other words, while a portion of Dr. Zaldivar's opinion about the contents of the November 14, 2001 chest x-ray is based on his inadmissible reading, his understanding of that chest x-ray is consistent with the other two admissible interpretations of the same film.

In his November 2003 deposition, EX 5, Dr. Zaldivar also indicated that he had reviewed the November 10, 2003 medical report by Dr. Fino which I have determined is not admissible. Thus, due to 20 C.F.R. § 725.414 (3) (i), another medical opinion containing inadmissible evidence issue arises. Since Dr. Zaldivar neither provided any further information on Dr. Fino's conclusions nor used Dr. Fino's report to support his own conclusions, I believe Dr. Zaldivar's deposition may remain in evidence.

[3]In his medical report, Dr. Zaldivar additionally indicated that he reviewed Dr. Gayler's interpretation of the same film. The record does not contain Dr. Gayler's interpretation which would also be inadmissible because it exceeds the evidentiary quota on chest x-ray interpretations.

Also, in his medical record review, Dr. Branscomb indicated that he had interpreted five chest x-rays. Based on the previous discussion, his interpretations exceed the evidentiary limitations in this case and once again raise an issue about the admissibility of Dr. Branscomb's entire medical opinion. While I will not consider Dr. Branscomb's own chest x-ray interpretations, I ultimately have determined his medical record review remains admissible. His conclusion that the preponderance of the chest x-rays does not show the presence of pneumoconiosis is consistent with my determination concerning the films (*see* page 8).

Finally, as noted above, Mr. Isom passed away shortly after the hearing. On February 23, 2004, from Claimant's counsel, on behalf of Mrs. Isom, I received a copy of Mr. Isom's death certificate, which I have marked as CX 2 and admitted into evidence. On March 22, 2004, I also received an autopsy report, which I have marked as CX 3 and admitted into evidence. Through the close of the record in August 2004, I received no evidence from the Employer's counsel concerning Mr. Isom's death.

In light of the above comments, my decision in this case is based on the hearing testimony and the following exhibits admitted into evidence: DX 1 to DX 37, CX 1 to CX 3, EX 1, EX 2, and EX 4 to EX 6.[4]

ISSUES

1. Whether Mr. Isom had pneumoconiosis.

2. If Mr. Isom had pneumoconiosis, whether his disease arose out of coal mine employment.

3. Whether Mr. Isom had a totally disabling respiratory impairment.

4. If Mr. Isom was totally disabled, whether his total disability was due to coal workers' pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Isom had post-1969 coal mine employment; b) the length of his coal mine employment was at least twenty-five years; c) Eastern Associated Coal Company is the responsible operator; and d) Mrs. Lottie B. Isom is a dependent for the purposes of augmenting any benefits that may be payable under the Act. (TR, pages 16, 17, and 24).

[4]As indicated at the hearing (TR, page 16), while I admitted EX 5 and EX 6, as identified, I left the record open for the actual receipt of the documents. On December 23, 2003, I received the depositions of Dr. Zaldivar, EX 5, and Dr. Branscomb, EX 6.

Preliminary Findings

Born on February 17, 1925, Mr. Isom married Mrs. Lottie B. Isom on March 19, 1949. Mr. Isom started mining coal in 1946 and accumulated 25 years of coal mine employment by the time he stopped working as a miner in 1982. Over the course of his career as a coal miner, Mr. Isom worked as a hand loader, rock driller, conveyor loader, and motorman. When the mine shut down in 1982, he had worked as a mainline motorman for over a year. Usually, that job required little lifting or carrying and Mr. Isom characterized the associated physical labor as light. Occasionally, Mr. Isom also had to move 80 to 90 pound jacks to replace derailed cars, which involved heavy manual labor. (DX 1, DX 2, DX 10, DX 13 (mining history reported to Dr. Rasmussen (DX 13) and TR, pages 20 to 23)

Mr. Isom started smoking cigarettes after he left military service in 1946. He continued to smoke less than a pack a day for the next 40 years; he mostly quit in 1991. Towards the end of his life, Mr. Isom struggled with chronic shortness of breath and used oxygen therapy 24 hours a day. He passed away on January 12, 2004. (CX 1, DX 13 and TR, pages 23 and 24)

Issue #1 – Presence of Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[5] The regulatory definitions include both clinical, or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[6] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[7] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Isom had complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. As a result, to demonstrate that her husband had pneumoconiosis, Mrs. Isom will have to rely on autopsy/biopsy evidence, chest x-rays, or medical opinion to establish the presence of

[5]20 C.F.R. § 718.201 (a).

[6]20 C.F.R. § 718.201 (a) (1) and (2) (emphasis added).

[7]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

pneumoconiosis. Additionally, under the guidance of *Compton*,[8] I must consider all the medical evidence together to determine whether Mr. Isom had pneumoconiosis.

Autopsy/Biopsy Evidence

(Note: the following summary, and other remaining portions of this decision, contain detailed information obtained from the autopsy of Mr. Isom submitted to support his claim for black lung disability benefits. While respecting the dignity and privacy of the deceased, some discussion of the detailed observations is necessary because I find the medical information relevant on determining whether Mr. Isom had pneumoconiosis.)

Prior to discussing the reports on the examination of Mr. Isom's lung tissue, a review of the regulatory provisions on the requisite standard for diagnosing pneumoconiosis based on a biopsy or an autopsy helps to understand their significance. The regulations define "medical" pneumoconiosis as a condition characterized by permanent deposition of substantial amounts of particulate matter, caused by coal dust exposure, in the lungs and "the fibrotic reaction of the lung tissue to that deposition," 20 C.F.R. § 718.201 (a) (1) (emphasis added). Such reaction may be characterized as coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silictuberculosis," 20 C.F.R. § 718.201 (a) (1). As a result, an autopsy or biopsy finding of anthracotic pigmentation, standing alone, is not sufficient to establish the presence of pneumoconiosis, 20 C.F.R. § 718.202 (a) (2).

Dr. Angel M. Cinco
(CX 3)

Dr. Cinco, a board certified pathologist,[9] performed an autopsy of Mr. Isom on January 20, 2004. Upon gross examination, the upper and middle lung surfaces were heavily pigmented with "coalescence black macular lesions;" the number of lesions diminished in the lower lobes. Upon dissection, Dr. Cinco found pigmented macular lesions with a few, scattered, "palpable dense fibrotic lesions of several centimeters." Under the microscope, the lung tissue samples revealed peripheral and central macular lesions, containing fibrous tissue "with deposits of coal dust," and wide zones of fibrosis containing coal dust pigment. The pathologist also noted macrophages associated with centrilobular and peripheral emphysema. Finally, the pericolic nodules had been replaced by "massive collagenized fibrous tissue containing anthracotic pigments and numerous" silica crystals. Based on his gross and microscopic examinations, Dr. Cinco diagnosed pulmonary anthracosilicosis, coal workers' pneumoconiosis with areas of pulmonary fibrosis, anthracosilicotic nodules in the peribronchial lymph nodes, and bilateral centrilobular emphysema.

[8] *See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

[9] I take judicial notice of Dr. Cinco's board certification and have attached the certification documentation.

Discussion

During Mr. Isom's autopsy/biopsy, Dr. Cinco found numerous areas of fibrotic reactions to the deposit of coal dust in both the lung tissue and lymph nodes. His observations and diagnosis of anthracosilicosis satisfy the medical definition of pneumoconiosis. As a result, Mrs. Isom is able to show the presence of pneumoconiosis in her husband's lungs through autopsy/biopsy evidence under 20 C.F.R. § 718.202 (a) (2).

Compton Analysis

Although Mrs. Isom has demonstrated the presence of pneumoconiosis through autopsy/biopsy evidence, the court in *Compton* mandates that I consider that evidence in conjunction with the other medical information in the record relating to the presence of pneumoconiosis, consisting of chest x-rays and other medical opinions.

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
February. 5, 1982	EX 2[10]	Dr. Thompson	Normal.
February 19, 1982	EX 2	Dr. Bassali	Normal.
September 19, 1982	EX 2	Dr. Bassali	Fractured right ribs.
April 2, 1997	EX 2	(Appalachian Regional)	Severe interstitial disease; pulmonary pneumoconiosis.
April 3, 1997	DX 20	Dr. Bassali	Severe diffuse chronic interstitial disease consistent with coal workers' pneumoconiosis.
January 17, 2001	EX 2	Dr. B. Patel	COPD; chronic lung changes and scarring.
June 19, 2001	DX 20	Dr. Cruz	Chronic interstitial lung changes; infiltrates present.
July 10, 2001	EX 2	----------	Nonspecific fibrosis; chronic obstructive pulmonary disease ("COPD").
October 31, 2001	DX 16	Dr. M. Patel, BCR, B[11]	Positive for pneumoconiosis, profusion 2/2,[12] category s/t opacities; [13] emphysema present.

[10]The chest x-ray interpretations identified with EX 2 were summarized by Dr. Zaldivar based on his review of Mr. Isom's treatment notes and are admissible under 20 C.F.R. § 725.414 (a) (4).

[11]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

[12]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he

(same)	DX 30	Dr. Scatarige, BCR, B	Negative for pneumoconiosis; idiopathic fibrosis is present.
November 14, 2001	DX 32	Dr. Wheeler, BCR, B	Negative for pneumoconiosis and silicosis; mild to moderate interstitial disease present.
(same)	EX 4	Dr. Scott, BCR, B	Negative for pneumoconiosis; nonspecific pulmonary fibrosis and minimal emphysema present.
November 21, 2001	EX 2	(Appalachian Regional)	Pneumonic infiltrates.
November 25, 2001	EX 2	Dr. Cruz	Clearing of infiltrates in right lung; no change in the left lung
November 27, 2001	EX 2	Dr. Cruz	Pulmonary fibrosis with scarring.
February 13, 2002	EX 2	Dr. Boustani	Nonspecific fibrosis.
March 4, 2003	CX 1	(Reported by Dr. N. Patel)	Bibasilar infiltrates, COPD, and pulmonary fibrosis.

Of the fifteen chest x-rays presented in the record, no disagreement exists concerning the respective findings for fourteen of the films. Based on the undisputed interpretations, I find the April 2, 1997 and April 3, 1997 radiographic studies are positive for pneumoconiosis. Likewise, February 5, 1982, February 19, 1982, September 19, 1982, January 17, 2001, June 19, 2001, July 10, 2001, November 14, 2001, November 21, 2001, November 25, 2001, November 27, 2001, February 13, 2002, and March 4, 2003 chest x-rays are negative for pneumoconiosis.

In regards to the remaining chest x-ray, dated October 31, 2001, two similar-well qualified radiologists reached different conclusions. While Dr. Patel found sufficient evidence of pneumoconiosis, Dr. Scatarige did not. Their professional dispute renders the October 31, 2001 chest x-ray inconclusive on the issue of pneumoconiosis.

Setting aside the one inconclusive study, only two of the remaining fourteen films are positive for pneumoconiosis. As a result, the preponderance of the chest x-ray evidence is negative for the presence of black lung disease and does not support a finding of pneumoconiosis under the provisions of 20 C.F.R. § 718.202 (a) (1).

However, for two reasons, I find the radiographic studies do not overcome, or offset, the probative value of Dr. Cinco's autopsy/ biopsy observations that Mr. Isom had pneumoconiosis.

First, pneumoconiosis is considered to be a latent and progressive disease, 20 C.F.R. § 718.201 (c). As a result, the insufficiency of the radiographic evidence from 1982 through

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considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

[13]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

March 2003 to establish pneumoconiosis does not necessarily negate, or represent a significant inconsistency with, Dr. Cinco's January 2004 autopsy finding of pneumoconiosis.

Second, and more important, while the medical experts disagreed on whether the chest x-rays showed the presence of pneumoconiosis, they almost all reported the presence of interstitial changes and pulmonary fibrosis. Their disagreement arose over the cause of the fibrosis. For example, Dr. M. Patel attributed the fibrosis to pneumoconiosis, while Dr. Scatarige believed the cause was idiopathic, or unknown. To specifically identify the source of the fibrosis, Dr. Zaldivar indicated that a biopsy of lung tissue was the ideal diagnostic tool (EX 2 and EX 5; *see* the following evidentiary summary, pages 10 and 11). As part of his autopsy procedure, Dr. Cinco performed the recommended lung tissue biopsy analysis. His microscopic examination found coal dust was at least one source of the fibrosis noted in the numerous radiographic images of Mr. Isom's lungs.

Consequently, although the preponderance of the radiographic images of Mr. Isom's chest, standing alone, are insufficient to establish the presence of pneumoconiosis, I conclude the more specific biopsy findings have greater probative value in identifying the cause of the pulmonary fibrosis and determining whether Mr. Isom had pneumoconiosis.

Medical Opinion

Dr. Narendra Patel
(DX 20, CX 1, and CX 2)

Between April 2 and April 8, 1997, Dr. Patel, board certified in gastroenterology and internal medicine,[14] treated Mr. Isom in the hospital for cyanosis and severe hypoxemia. Upon admission, Mr. Isom's arterial blood gas test result revealed a severely reduced oxygen exchange capability. Dr. Patel placed Mr. Isom on oxygen therapy and administered nebulizer treatments, steroids, and antibiotics. A chest x-ray showed the presence of pneumoconiosis. Mr. Isom's hypoxemia responded well to oxygen therapy. Dr. Patel believed Mr. Isom had severe chronic obstructive pulmonary disease ("COPD") and pulmonary fibrosis. In addition to coronary artery disease, the physician diagnosed severe hypoxia, COPD, acute bronchitis, and chronic interstitial lung disease, secondary to coal workers' pneumoconiosis.

Between March 4 and March 11, 2003, Dr. Patel hospitalized Mr. Isom for pneumonia and hypoxia. Mr. Isom presented on March 4, 2003 with worsening cough and shortness of breath. Mr. Isom had been a coal miner for 25 and a half years and smoked cigarettes 30 to 40 years. A chest x-ray indicated the presence of infiltrates associated with pneumonia and pulmonary fibrosis. After increased oxygen therapy and medication, Mr. Isom's condition improved and he was released on March 11th. Upon discharge, Dr. Patel diagnosed acute chronic respiratory failure, pneumonia, COPD, pulmonary fibrosis, coronary artery disease and coal workers' pneumoconiosis.

[14]I take judicial notice of Dr. Patel's board certification and have attached the certification documentation.

On January 15, 2004, Dr. Patel signed Mr. Isom's death certificate, indicating that he had passed away on January 12, 2004. The immediate causes of death were respiratory failure and COPD. Significant conditions contributing to death were coal workers' pneumoconiosis and pulmonary fibrosis. Although an autopsy had been accomplished, Dr. Patel noted that he did not have the autopsy findings before him at the time he determined the causes of death.

Dr. D. L. Rasmussen
(DX 13)

On October 31, 2001, Dr. Rasmussen, board certified in internal medicine,[15] conducted a pulmonary examination. Mr. Isom had over twenty years of coal mine employment. He had smoked cigarettes at the rate of half a pack a day between 1946 and 1991. Mr. Isom reported worsening shortness of breath and wheezing upon exertion. In 1977, he had suffered a heart attack.

During the physical examination, Dr. Rasmussen found moderately to markedly reduced breath sounds. The chest x-ray was positive for pneumoconiosis. While the pulmonary function test showed a slight obstructive impairment, the arterial blood gas study met the regulatory threshold for total disability indicating marked hypoxia at rest. Based on Mr. Isom's history of coal mine employment and the chest x-ray, Dr. Rasmussen diagnosed coal workers' pneumoconiosis. Dr. Rasmussen also opined that Mr. Isom had emphysema/fibrosis due to his exposure to both coal dust and cigarette smoke. Due to his resting hypoxia, Mr. Isom did not have the pulmonary capacity to return to his last job as a coal miner. The two pulmonary risk factors associated with his disability were coal dust and cigarette smoke. Since coal dust can cause emphysema and fibrosis, Dr. Rasmussen concluded that coal dust was a significant contributing factor in Mr. Isom's respiratory disability.

Dr. George L. Zaldivar
(DX 31, EX 2, and EX 5)

On November 14, 2001, Dr. Zaldivar, board certified in pulmonary disease and internal medicine, examined Mr. Isom. A former coal miner with 25 and a half years of coal dust exposure, Mr. Isom presented with chronic shortness of breath, even with oxygen therapy. Mr. Isom had smoked cigarettes from 1946 to 1991 at about a half a pack a day. Upon physical examination, Dr. Zaldivar heard bilateral crackles. The chest x-ray interpretation showed idiopathic fibrosis; the film was negative for coal workers' pneumoconiosis. The pulmonary function test indicated an irreversible, moderate obstruction and diffusion impairment. Dr. Zaldivar diagnosed abnormal lungs with crackles associated with pulmonary fibrosis. The cause of the fibrosis was unknown. According to Dr. Zaldivar, the "most common cause of pulmonary fibrosis was idiopathic." He added that a lung "biopsy is done to determine the exact cause of fibrosis." The absence of a lung biopsy in Mr. Isom's case was not a problem because "simple coal workers' pneumoconiosis is never a cause of pulmonary fibrosis." Dr. Zaldivar attributed Mr. Isom's noted pulmonary impairment, which standing alone was totally disabling, to the pulmonary fibrosis. In turn, that fibrosis was not related to Mr. Isom's coal mine employment.

[15]I take judicial notice of Dr. Rasmussen's board certification and have attached the certification documentation.

Even if Mr. Isom had simple coal workers' pneumoconiosis, Dr. Zaldivar concluded it would not be a cause of the pulmonary fibrosis which is the source of the pulmonary disability.

On October 28, 2003, Dr. Zaldivar reviewed additional medical evidence, including old medical treatment notes, Dr. Rasmussen's pulmonary evaluation and recent chest x-rays. Upon consideration of the additional evidence, Dr. Zaldivar's diagnoses remained unchanged. Mr. Isom had a severe interstitial pulmonary fibrosis, "absolutely unrelated to coal workers' pneumoconiosis." Based on the radiographic evidence, Dr. Zaldivar opined the pulmonary fibrosis was present by the mid-1990s. Dr. Zaldivar recommended a contrast CT scan to help further analyze the fibrosis. Although a lung biopsy would be a more "ideal" diagnostic test; Mr. Isom's hypoxemia probably precluded such a procedure. Mr. Isom also had an obstructive impairment that was not totally disabling. This condition was related to his cigarette smoking.

In a November 2003 deposition, Dr. Zaldivar noted that he had also reviewed Dr. Branscomb's report, which mentioned Mr. Isom's bouts with pneumonia. Dr. Zaldivar explained that pneumonia may cause scarring in the lungs. Dr. Zaldivar also highlighted that the November 2001 carbon monoxide test he conducted on Mr. Isom produced a reading consistent with a cigarette smoker even though Mr. Isom claimed to have stopped smoking cigarettes ten years earlier. Dr. Zaldivar repeated his diagnosis that Mr. Isom had idiopathic pulmonary fibrosis. The only certain way to identify the cause of the fibrosis was a lung biopsy. The pulmonary fibrosis caused Mr. Isom's diffusion impairment. According to Dr. Zaldivar, coal dust never causes pulmonary fibrosis. On the other hand, "rock dust can cause silicosis and silicosis can cause fibrosis," which is "easily seen radiograhically." Finally, the location of Mr. Isom's fibrosis in the lower lobes was inconsistent with coal workers' pneumoconiosis which develops in the upper lobes of the lungs.

Dr. Ben V. Branscomb
(EX 1 and EX 6)

In mid-October 2003, Dr. Branscomb, a Professor Emeritus of pulmonary medicine, conducted a review of the medical record, including treatment notes, radiographic chest films, and the medical reports by Dr. N. Patel and Dr. Rasmussen. Mr. Isom had more than twenty-five years of coal mine employment, most of that exposure was above ground. His cigarette smoking history had been reported to be as high as 40 to 50 pack-years.[16] Some medical notes suggested Mr. Isom may have continued to smoke cigarettes through 2003 even though he claimed to have stopped smoking in 1991.

The medical treatment notes chronicled Mr. Isom's early struggle with cardiac artery disease. After fracturing some ribs, Mr. Isom also began to experience periodic bouts of pneumonia. The preponderance of the chest x-ray evidence was negative for coal workers' pneumoconiosis. The location of the pulmonary fibrosis displayed in the radiographic studies indicate the most likely cause was Mr. Isom's recurring pneumonia. The recent pulmonary function studies did not show a significant obstructive impairment. The abnormal arterial blood gas tests were attributable to the pneumonia-related fibrosis and Mr. Isom's obesity. At the same time, in addition to being totally disabled by coronary artery disease, Mr. Isom was "probably

[16]A pack-year equals the consumption of one pack of cigarettes per day for one year.

totally disabled by basal, pulmonary fibrosis alone, causing hypoxemia." His exposure to coal mine dust did not contribute to either impairment.

In a November 18, 2003 deposition, Dr. Branscomb reiterated his opinion that Mr. Isom does not have coal workers' pneumoconiosis. Likewise, his cardiac issues, which relate to the left side of his heart, do not involve cor pulmonale. The physician suggested that Mr. Isom's fractured ribs may be one cause of his pulmonary problems. Mr. Isom's obesity may also be contributing to his breathing problem because it prevents "full inspiration" by his lungs. Mr. Isom's pulmonary fibrosis may be due to his problem with esophageal regurgitation, or gastroesophageal reflux disease ("GERD"), which can cause scarring of the lungs. Additionally, Mr. Isom's pneumonia could have caused lung scarring. The fibrosis' location in the lower lungs also indicates coal dust was not a cause.

Although the pulmonary function tests show that Mr. Isom can move air in and out of his lungs effectively, his ability to obtain oxygen from the air is diminished. At the same time, Dr. Branscomb noted that while the arterial blood gas studies showed low diffusion capacity, at about the same time, at least one doctor reported near normal diffusion using a different test method. Such variability in diffusion capacity is inconsistent with coal workers' pneumoconiosis, which is "an unremitting condition." Nevertheless, Mr. Isom's "reduction in oxygen tension is fairly severe" and disabling standing alone. Some medical studies have indicated that coal dust exposure may cause a reduction in oxygen transfer capacity while pulmonary function remains normal. However, those studies only related to a small reduction in capacity. Mr. Isom is experiencing a severe oxygen tension reduction which has never been linked to coal dust exposure, in the absence of "severe obvious" simple coal workers' pneumoconiosis "or complicated pneumoconiosis. In other words, x-ray positive changes." A large reduction in oxygen tension has not been associated with "low levels of simple pneumoconiosis or in legal pneumoconiosis. . ."

For these reasons, Dr. Branscomb believes Mr. Isom's pulmonary impairment is not related to his coal mine employment.

Discussion

On the issue of whether Mr. Isom has pneumoconiosis, the four physicians to consider his case split their opinions. Dr. Patel, Mr. Isom's treating physician, and Dr. Rasmussen diagnosed coal workers' pneumoconiosis. Dr. Zaldivar and Dr. Branscomb disagree and opined that Mr. Isom did not have the disease. In reaching their respective opinions, the critical determining factor was their belief regarding the source of the fibrosis identified in the chest x-rays. Dr. Patel and Dr. Rasmussen believed the fibrosis was caused by coal dust exposure. Dr. Zaldivar and Dr. Branscomb adamantly stated coal dust could not have caused the fibrosis.

In weighing the relative probative value of these diverse opinions, I note that the preponderance of the chest x-rays were negative for pneumoconiosis. As a result, prior to Mr. Isom's death and the subsequent autopsy, the opinions of Dr. Zaldivar and Dr. Branscomb were more consistent with the radiographic evidence and correspondingly more probative than the

opinions of Dr. Patel and Dr. Rasmussen such that the preponderance of the more probative medical opinion did not support a finding of pneumoconiosis under 20 C.F.R. § 718.202 (a) (4).

However, neither Dr. Zaldivar nor Dr. Branscomb provided any comment about Dr. Cinco's autopsy findings which clearly showed a connection between the pulmonary fibrosis and coal dust. Apparently, even after Mr. Isom's death, their conclusions about the lack of any causal relationship between the pulmonary fibrosis and coal dust continued to rest on their evaluation of the chest x-ray evidence. Yet, as previously discussed, I have already determined that those radiographic interpretations do not outweigh Dr. Cinco's specific biopsy findings. Consequently, post-mortem, the principal foundation for the conclusions of Dr. Zaldivar and Dr. Branscomb that the radiographic fibrosis was not related to coal dust has been grievously undermined, causing a corresponding serious erosion of the probative value of their assessments. In considering those diminished assessments in comparison with Dr. Cinco's autopsy conclusion, I find the conclusions of Dr. Zaldivar and Dr. Branscomb that Mr. Isom did not have pneumoconiosis do not outweigh the autopsy diagnoses of coal workers' pneumoconiosis and anthracosilicosis.

In contrast, rather than represent contrary evidence, the diagnoses of pneumoconiosis by Dr. Patel and Dr. Rasmussen were validated by Dr. Cinco's autopsy findings.

In summary, as required by *Compton,* I have considered that neither the preponderance of the chest x-ray evidence nor the medical opinion establishes the presence of pneumoconiosis in Mr. Isom's lungs. Yet, due to the specificity of Dr. Cinco's pathology findings demonstrating the presence of coal workers' pneumoconiosis and anthracosilicosis, I consider his examination more probative on the issue of whether Mr. Isom had pneumoconiosis. Accordingly, through the more probative autopsy/biopsy evaluation, Mrs. Isom has proven that Mr. Isom had pneumoconiosis, the first requisite element of entitlement.

Issue # 2 – Pneumoconiosis Arising Out of Coal Mine Employment

Once a claimant has proven the existence of pneumoconiosis, 20 C.F.R. § 718.203 (a) (2001) requires that he also establish that his pneumoconiosis arose at least in part from his coal mine employment. According to 20 C.F.R. § 718. 203 (b) (2001), if the claimant was employed in coal mining for ten or more years, a rebuttable presumption that the pneumoconiosis is due to coal mine employment exists.

Based on the parties' stipulation of fact, Mr. Isom had at least twenty-five years of coal mine employment. Consequently, a regulatory presumption is established that his pneumoconiosis was related to his work as a coal miner. In light of the autopsy findings, little probative evidence exists to indicate the pneumoconiosis and pulmonary fibrosis did not stem from his work in coal mines thereby rebutting the presumption. As a result, I find Mr. Isom had coal workers' pneumoconiosis.

Issue # 3 – Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

The record contains no evidence of complicated pneumoconiosis. In regards to cor pulmonale, Mr. Isom had struggled with coronary artery disease. However, Dr. Branscomb's analysis of the condition, highlighting the left side of the heart as the affected area eliminates cor pulmonale with right-sided congestive heart failure as a cause of disability. Thus, Mrs. Isom must demonstrate total respiratory, or pulmonary, disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[17] post[18]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[19] pre Post**	**Comments**
DX 12	Oct 31, 2001 Dr. Rasmussen	76 68"	2.35	4.36	63	54%	No[20]	Slight obstruction
DX 31	Nov. 14, 2001 Dr. Zaldivar	76 69"	2.38 2.41	4.28 4.49		56% 54%	No[21]	Moderate, irreversible obstruction

[17]Test result before administration of a bronchodilator.

[18]Test result following administration of a bronchodilator.

[19]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[20]The qualifying FEV1 number is 1.69 for age of 76 (the maximum age in the table is 71) and 68"; the corresponding qualifying FVC and MVV values are 2.20 and 67, respectively.

Neither pulmonary function test meets the regulatory total disability standards. Consequently, Mrs. Isom is unable to establish total disability through pulmonary function tests under 20 C.F.R. § 718.204 (b) (2) (i).

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified**[22]	**Comments**
DX 20	Apr. 2, 1997 Dr. Patel	35.6	46	Yes[23]	(Upon admission into the hospital)
DX 20	(same)	36.9	54	Yes[24]	(After oxygen therapy)
DX 20	Apr. 7, 1997 Dr. Patel	39.2	67	No[25]	(After hospitalization & oxygen therapy)
DX 12	Oct. 31, 2001 Dr. Rasmussen	34	50	Yes[26]	Marked resting hypoxia (Acceptable per Dr. Gaziano, DX 15)
EX 2[27]	Nov. 21, 2001 Dr. Patel	33.6	51	Yes	(With oxygen therapy and hospitalization)
CX 1	Mar. 4, 2003 Dr. N. Patel	34.5	47	Yes[28]	(With oxygen therapy & pneumonia)
CX 1	Mar. 5 to 10, 2003 Dr. N. Patel	36.1	75	No	(With increased oxygen and hospitalization)
CX 1	Mar. 11, 2003	32.5	65	Yes[29]	(With increased oxygen and upon hospital discharge.

[21]The qualifying FEV1 number is 1.79 for age of 76 and 69″; the corresponding qualifying FVC and MVV values are 2.31 and 72, respectively.

[22]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[23]For the pCO^2 of 36 or below, the qualifying pO^2 is 64, or less.

[24]For the pCO^2 of 37 or below, the qualifying pO^2 is 63, or less.

[25]For the pCO^2 of 39 or below, the qualifying pO^2 is 61, or less.

[26]For the pCO^2 of 34 or below, the qualifying pO^2 is 66, or less.

[27]Reported by Dr. Zaldivar during his review of Mr. Isom's medical treatment records.

[28]For the pCO^2 of 35 or below, the qualifying pO^2 is 65, or less

[29]For the pCO^2 of 33 or below, the qualifying pO^2 is 67, or less

The preponderance of the arterial blood gas studies satisfy the regulatory total disability criteria and demonstrate that even with oxygen therapy, Mr. Isom suffered a totally disabling incapacity to place sufficient oxygen in his blood stream. Mr. Isom was totally disabled under the provisions 20 C.F.R. §§ 718.204 (b) (2) (iii).

Medical Opinion

Total disability may also be established under 20 C.F.R. §718.204 (b) (2) (iv) through the preponderance of the more probative medical opinion. Under this regulatory provision, total disability may be found through reasoned medical opinion:

> if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b) (1) of this section.

Twenty C.F.R. §718.204(b) (1) defines such employment as either his usual coal mine work or other gainful employment requiring comparable skills. To evaluate total disability under these provisions, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of his respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

Based on Mr. Isom's report to Dr. Rasmussen that he occasionally had to move heavy jacks as a motorman, I find he engaged in heavy manual labor in his last coal mine job.

Having established the physical requirements of Mr. Isom's last coal mining job, I turn to the medical opinion in the present claim to assess whether he is totally disabled. In that regard, Dr. Rasmussen, Dr. Zaldivar, and Dr. Branscomb agree – Mr. Isom had a totally disabling pulmonary condition. That is, Mr. Isom is also totally disabled under the provisions of 20 C.F.R. §718.204 (b) (2) (iv).

Issue # 4 – Total Disability Due to Coal Workers' Pneumoconiosis

Because Mrs. Isom has established three of the four requisite elements for her husband's entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Under 20 C.F.R. § 718.204 (c) (1), absent regulatory presumptions in favor of a claimant,[30] the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his

[30]20 C.F.R. § 718.305 (2001) (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the claimant is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (2001) (for claims filed before January 1, 1982, if the miner has fifteen years or more of coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (2001) (a presumption exists when a survivor files a claim prior to June 30, 1982).

respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204 (c) (2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

In considering the medical opinion, I first note that Dr. Patel and Dr. Cinco did not specifically discuss whether Mr. Isom was totally disabled and the source of such disability. The remaining three physicians once again disagree on the issue. According to Dr. Rasmussen, Mr. Isom had a total respiratory disability due in part to pulmonary fibrosis attributable to his long-term exposure to both cigarette smoke and coal dust. Understandably, since neither Dr. Zaldivar nor Dr. Branscomb believed Mr. Isom had coal workers' pneumoconiosis, they did not believe it played any role in his respiratory disability.

Notably, all three physicians identified the pulmonary fibrosis as a significant pulmonary condition causing Mr. Isom's inability to obtain sufficient oxygen from the air. As previously discussed, their professional disagreement centered on the cause of fibrosis.

Dr. Branscomb cited fractured ribs, recurring pneumonia, and GERD as possible causes for the pulmonary fibrosis. The Professor Emeritus specifically precluded any possibility in Mr. Isom's case that coal dust played a role in the development of the fibrotic-related impairment because he did not have radiographic evidence of severe coal workers' pneumoconiosis or complicated pneumoconiosis. Based on the more probative autopsy/biopsy evaluation, contrary to Dr. Branscomb's expert opinion, I have concluded that Mr. Isom's pulmonary fibrosis was related to his coal dust exposure. In light of that finding, since Dr. Branscomb dismissed coal dust as an etiology, his assessment has little probative value in determining whether Mr. Isom's respiratory impairment was due in part to coal workers' pneumoconiosis.

Dr. Zaldivar essentially believed the cause of the disabling pulmonary fibrosis was unknown, or idiopathic. In a manner similar to Dr. Branscomb, he adamantly adhered to the principle that simple coal workers' pneumoconiosis does not cause pulmonary fibrosis. Consequently, due to Dr. Cinco's pathology observations connecting Mr. Isom's pulmonary fibrosis with coal dust, Dr. Zaldivar's opinion suffers the same probative deficiency in determining whether coal workers' pneumoconiosis played a role in Mr. Isom's inability to sufficiently oxygenate his blood.

I have considered Dr. Zaldivar's statement that even if Mr. Isom had simple coal workers' pneumoconiosis, it played no role in his impairment. That statement has little merit. In explaining his position, Dr. Zaldivar explained that since simple coal workers' pneumoconiosis does not cause pulmonary fibrosis and Mr. Isom's respiratory capacity is impaired by such fibrosis, pneumoconiosis was not a factor.

In contrast to Dr. Zaldivar and Dr. Branscomb, Dr. Rasmussen did not preclude coal dust as a causation factor in the development of Mr. Isom's pulmonary fibrosis. In fact, he specifically stated that coal dust can cause fibrosis. In addition to radiographic evidence of coal workers' pneumoconiosis, Dr. Rasmussen concluded Mr. Isom's emphysema and fibrosis were due to both cigarette smoke and coal dust exposure. Further, the two pulmonary risk factors

contributing to Mr. Isom's disabling hypoxemia were cigarette smoke and coal dust. Since Dr. Rasmussen's evaluation is the only medical opinion consistent with the more probative pathology evidence showing coal dust-related pulmonary fibrosis, his opinion on the cause of Mr. Isom's respiratory disability has greater probative weight than the contrary consensus of Dr. Branscomb and Dr. Zaldivar. Based on Dr. Rasmussen's more probative opinion that coal dust was one of two contributing factors in the development of Mr. Isom's resting hypoxia, I find Mr. Isom's total respiratory disability was due to coal workers' pneumoconiosis.

CONCLUSION

Based on Dr. Cinco's more probative autopsy/biopsy report and the length of her husband's coal mine employment, Mrs. Isom has proven that Mr. Isom had coal workers' pneumoconiosis. The preponderance of both the arterial blood gas studies and medical opinion establishes that Mr. Isom suffered a totally disabling respiratory impairment. Through Dr. Rasmussen's more probative medical opinion, Mrs. Isom has also demonstrated that her husband's total respiratory disability was due in part to coal workers' pneumoconiosis. Accordingly, Mr. Isom's claim for disability benefits under the Act must be granted.

Dates of Entitlement

Initiation of Benefits

Under 20 C.F.R. § 725.503 (b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to

the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset").

Although Mr. Isom filed his claim for disability benefits on April 26 2001, some evidence exists in the record that his onset of disability occurred earlier. Two arterial blood gas studies demonstrate that at the beginning of April 1997 Mr. Isom was hospitalized with a totally disabling inability to oxygenate his blood. On the other hand, once the exacerbation of his breathing problem was treated and he was released from the hospital on April 7, 1997, the discharge arterial blood gas study did not reach the total disability threshold. Consequently, I find insufficient evidence to place the onset of total disability due to coal workers' pneumoconiosis at some time prior to April 2001.

Following submission of Mr. Isom's claim, Dr. Rasmussen's medical evaluation and arterial blood gas test in October 2001 established Mr. Isom's total disability due to coal workers' pneumoconiosis. Since there is no showing that Mr. Isom was not also totally disabled between April 2001 and the October 2001 DOL pulmonary examination, I find his black lung disability benefits are payable beginning April 1, 2001.

Termination of Benefits

According to 20 C.F.R. § 725.203 (b) (1), the last month a claimant is entitled to black lung disability benefits is "the month before the month during which. . . the miner dies." Since Mr. Isom passed away on January 12, 2004, the last month of his entitlement to disability benefits was December 2003.

Augmentation

Benefits under the Act may be augmented for a person who meets the criteria of spouse under 20 C.F.R. § 725.204 and the dependency requirements of 20 C.F.R. § 725.205 (2001). Based on the parties' stipulation of fact, I find that Mrs. Lottie B. Isom was a qualified spouse and met the regulatory requirements for spousal augmentation of Mr. Isom's black lung disability benefits.

Attorney Fees

Counsel for the Claimant has thirty calendar days from receipt of this decision and order to submit an application for attorney fees in accordance with 20 C.F.R. §§ 725.365 and 725.366.

With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen calendar days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with this claim.

ORDER

The claim of MR. JOHNIE H. ISOM for benefits under the Act is **GRANTED**. The Employer, EASTERN ASSOCIATED COAL COMPANY, is ordered to pay all benefits to which MR. JOHNIE H. ISOM was entitled under the Act and Regulations, augmented for his dependent spouse, MRS. LOTTIE B. ISOM. Benefits shall commence April 1, 2001 and continue monthly through December 2003.

SO ORDERED:

A

Richard T. Stansell-Gamm
Administrative Law Judge

Date Signed: January 5, 2005
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties
Certification:

Angel M. Cinco, MD

Certified by the American Board of Pathology in:

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Attachment No. 2

American Board of Medical Specialties
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Attachment No. 3

American Board of Medical Specialties
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